

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-032531

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 146

Primary Registration District No. 3026

Registrar's No. 386

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED AUG 28 1963

1. PLACE OF DEATH a. COUNTY Jackson		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Jackson	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN Independence		c. CITY OR TOWN Independence	
Length of stay in 1b 16 yrs.		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 705 Apache Drive.		d. STREET ADDRESS (If outside, give location) 218 S. Cyrslar	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last Leah Alice Denton			4. DATE OF DEATH Month Day Year August 14 1963		
5. SEX Female	6. COLOR OR RACE White	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 11-13-1891	9. AGE (last birthday) 71	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Music Teacher		10b. KIND OF BUSINESS OR INDUSTRY Music		11. BIRTHPLACE (City and state or country) Beardstown, Illinois	
12. CITIZEN OF WHAT COUNTRY USA		13a. FATHER'S NAME Martin Shoemaker			
13b. MOTHER'S MAIDEN NAME Sprague		14. NAME OF HUSBAND OR WIFE Samuel J. Denton			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no None		16. SOCIAL SECURITY NO. Earl Denton		17. INFORMANT 705 Apache Dr. Indep. Mo.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary heart failure		INTERVAL BETWEEN ONSET AND DEATH 2 weeks
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) Arteriosclerotic cardiovascular disease		Year
DUE TO (c)		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 1960 , to 8/14/63 and last saw her alive on 7/26/63 Death occurred at 938 m on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Degree or title) RW Keane MD		22b. ADDRESS 10901 Union Road, Independence	
22c. DATE SIGNED 8/15/63			
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal	23b. DATE Aug 17, 1963	23c. NAME OF CEMETERY OR CREMATORY City Cemetery	
23d. LOCATION (City, town, or county) Beardstown Illinois			
24. FUNERAL DIRECTOR ADDRESS Roland R. Speaks Independence, Mo.		25. DATE RECD. BY LOCAL REG. 8-16-63	
26. REGISTRAR'S SIGNATURE Alba T. Craig			

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DOCUMENT

BY AFFIDAVIT OF

VS 300 Rev. 4/59	DATE AMENDED	
1 7005		
2 27005		
3		
4 1		
5 2		
6		
7 1		
8 2		
9 9422.1		
10		
11		
12 9000		
13 10		

1000000000

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed Wayne Smith

Licensed Embalmer No. 5081

P. O. Address Indep. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

8-16-63